# HEALTH POLICY FOR KERALA

(DRAFT)

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A health policy formulation should be aimed at achieving the greatest possible benefit for the maximum number of the population. Considering the vastness and diversity of India, separate state level health policy documents are warranted in spite of the existence of the national health policy. This is particularly relevant for Kerala which has a distinctly different health profile from the rest of the country.

Kerala has made remarkable advances in basic health indicators of its population. According to the latest available reports, the crude death rate for Kerala is 5.9, infant mortality rate 22/1000 live births and life expectancy at birth, 67 for males and 70 for females. The corresponding all India figures are 10.5, 94, 56 (males) and 57 (females) respectively. This distinguishes Kerala not only from the rest of India but also from a large number of less developed countries. In terms of achievement of health indicators, Kerala can be placed among such high achievers as China, Cuba, Costa Rica and Sri Lanka. There are several social and political dimensions common to all these societies such as low birth and death rates, sex ratio favouring the female, higher female life expectancy, low infant mortality with a reduced rural-urban difference, and lower rate of disability. Major causative factors attributed to better health status by social scientists have been, among other things: high female literacy, a good public distribution system of food, land reforms, better roads and communication, better utilisation of health care facilities, organised social and political movements, and the peri-urban nature of the state.

This general picture, however, is somewhat marred by the presence of high prevalence of morbidity in the population. According to the KSSP survey 1987, 206/1000 persons were acutely sick within a two-week period of the survey in Kerala: with chronic patients the rate was 138/1000 The KSSP survey also noted the dimorphic nature of the morbidity, ie., the presence of diseases of poverty along with diseases of a degenerative and chronic nature which are usually found in more advanced societies. There is also a socio-economic differential in morbidity and mortality, with the most affluent group being the most favoured. This is most marked in the under-five population: in this, the death rate varies from 3 — 12 in the richest households, to 15 — 39 in the poorest. The high rate of morbidity in Kerala can be attributed in part to its continued economic backwardness. To the extent that poverty related diseases dominate the picture, interventions in the health sector as well as outside it are warranted. Interventions in the health sector need to focus more on the preventive aspects of health care especially in the provision of safe drinking water and sanitary facilities. Since two thirds of our households have to be characterised as 'poor' or 'somewhat poor' (KSSP 1991), the need is for a broad-based policy of economic development which shall result in the betterment of the material circumstances of the poorer households. This calls for measures to improve the employment opportunities in the rural setting.

When we take into consideration the cost of treatment and the mandays lost due to illness, the burden falls to a considerable extent on poorer households also. But the credibility of public health care institutions with the people at large seems to be at a low point. There has been rapid expansion in the health care facilities in Kerala especially in the private sector. While the public health care institutions have played a crucial role in the expanding curative sector in the past decades, much of the facilities are still concentrated in urban areas. The fact that rural and urban areas are relatively well connected through transportation networks has benefitted the rural population.

This, however, cannot absolve the public health care institutions from their urban bias. Paradoxically such a bias has been moderated by the growth of the private health care system in the rural areas.

The task before the state now is to go from quantity to quality. Coverage of the population by hospitals and primary health centres seems to be quite remarkable with respect to the all India scenario. The qualitative aspects will have to include management of the institutions which would restore their lost credibility. The fact that even among the poorest households, only a minor proportion (33%) go to the government institutions regularly should come as an eye opener. The preventive health activities of primary health centres also do not seem to get the attention they deserve. The utilization of the large number of field staff need to be examined for their efficient re-deployment in rural areas. The reasons for the state's performance in the health sector lie largely outside the health sector. A more planned approach to health service development, should therefore, make a *large marginal* contribution to improving health indices further. This should include administratve and financial decentralisation of the health delivery system. The state sector should concentrate on (1) providing primary services to the poorer sections, including covering geographically poorly accessible areas, (2) providing preventive services and health education to the masses, (3) running hospitals as models of *efficient human care*.

## HEALTH FINANCING FOR KERALA

Kerala spends around 15% of the state budget on health. Given the financial constraints of the state governments, it is not realistic to expect state expenditure on health to go up by very much. The trust of health policy in health financing and funding should be (a) cutting down of wastes and promoting efficient use of the available resources, and (b) finding opportunities of novel ways of funding health care outside of government allocations.

The real picture in health financing in Kerala can be summed up as:

(1) Centralised state sector where the expenditure is totally met by the tax revenues of the government: user charges are minimal or not realised to any practicable extent;

(2) Private sector which is fully financed by user charges. There is practically no health insurance available, even though many private and government employees have medical reimbursement benefits.

What complicates the picture is the fact that private practice is widespread among government doctors. Though they are not supposed to charge money for services rendered in the government hospitals, in practice in many situations only the paying patient gets the benefit of prompt service. Thus government's budget expenditure on health is a poor proxy for the total health expenditure in the state.

Health spending on the government's part is growing at a rate greater than both the total government expenditure in the state, and the state's domestic product. It has been estimated that health spending forms 2-3% of the state domestic product, considering only what the government spends. This estimation has been done from data pertaining to the sixties and seventies mostly. If we consider the hidden costs of health care in the government sector, such as private practice, and the size of the private sector in health, we can safely assume that about 3 times this figure, ie., around 7-9% of the state domestic product, is spent on health. This is not very far behind such advanced countries such as the U S A which spends around 11% of its domestic product on health. It has to be emphasized again that health spending in the government sector is very unlikely to expand in the future.

The problem of finding increasing resources for the public sector is inextricably linked to the management of that sector.

Detailed studies are needed to unravel the pattern of spending with respect to capital costs, equipment maintainance, salaries, consumables etc., and their increase over the years to see how major streamlining can be done. The major proportion of expenditure which goes to support the largely bureaucratic administrative machinery in health can be cut if hospitals are largely locally managed.

The private sector presents a different picture altogether. The increasing investments in this sector suggests that raising resources to expand facilities is not a problem: rather this is seen as an area of safe returns to investment. This brings us to the other sore point in health care, viz, whether the consumer is being exploited. Upto 14% of family income is being spent on health, which is a large proportion. Rates for similar procedures and products vary widely in the private sector. There is little accountability and less quality control.

Thus the central problem of health system financing in Kerala is to contain overall health spending while simultaneously finding resources to improve the level of care in state institutions. The following suggestions are made:

1. Streamlining administrative procedure, with an emphasis on decentralisation and local management. District and Taluk Hospitals should be brought under the control of District Councils and P.H. Cs under the Control of Panchayats. The local bodies with the help of domestically set up Hospital Development Committees should have the power to raise revenues and utilise them for betterment of conditions in the hospitals.

2. Introduction of user charges in the state sector with a differentiel tariff. A large proportion of those who use Government facilities now are able to pay at least partly for the services. Moreover, there is also the tendency to overuse services when they are free of cost. The principle behind charging should not be the recovery of costs or profit making;

rather charging should be a policy instrument calculated to achieve the following objectives: (a) prevent bypass of primary health care facilities by the introduction of bypass charges. Bypass charges should be levied to those who come to the major medical institutions without referal from the PHC' s. This way the referal system shall also be strengthened. But this becomes practicable only if PHC's are able to take care of the majority of health problems in the population. (b) discourage overuse by the influential sections of the population, by pricing adequatly the services rendered to them; and (c) improve the quality or services. for which purpose the revenues collected at the hospital should be utilised. It has to be emphasized here that charging should not be introduced at a flat rate for all users, because this introduces a further element of inequity into the already skewed provision of services. This is because flat charges which are fixed at a relatively low level do not really act as deterrent to overuse, whereas they may discourage use by the really needy poor people. Moreover, it should be recognized that provision of primary and preventive services, such as antenatal care, immunisation, delivery and postnatal care, routine dental care, and most minor surgery as well as non surgical care, should be free as a matter of right in the Government health services. Hence pricing should be introduced only after due consideration of all these factors.

3. Autonomy to government hospitals : Individual government hospitals should be encouraged to take and implement their own decisions regarding recruitment, purchase of equipment, new services to be introduced etc. There should prevail a spirit of healthy competition between various government and private hospitals in providing customer services.

4. Proper prioritization : Areas of health intervention that are vital t the health of the community, such as mother and child care, immunisation, antenatal care, infective diseases control etc. should have priority both in the government as well as private sector. Areas of priority should be revised

periodically. To encourage private hospitals to take up more work in these priority areas, incentives such as tax concessions should be introduced.

5. Social control of hospitals : At present there is absolutely no accountability for the health care institutions, especially in the private sector. Some form of social control should be introduced. A suggestion for consideration is the constitution of public health boards at the district level, under the district councils, with administrative control of all government health institutions as well as powers to regulate, license and inspect private hospitals. The state should develop a public health cadre to man these health boards, along with such other duties as collection and compilation of health information.

6. Newer and novel methods of health financing such as community funds and health insurance, should be thought of. The current system of reimbursement of medical expenses for state employees should be thoroughly revamped to cut out corrupt practices and wastage.

## HEALTH MANPOWER DEVELOPMENT

Kerala trains around 700 doctors per year. Besides this number, there are many students from the state who qualify outside the state and return to practice Considering the comparatively favourable doctor population of around 1/2400, future expansion of medical education is not warranted. On the other hand, the health professional training in the state is handicapped by top heavy approach, and there are inadequacies in the number of nurses and other paramedical staff. This has to be remedied on a priority basis. The resources for medical and health personnel training should be invested in improvement of guality of training. It is to be remembered that whereas about ten years ago the medical colleges lead the state in state of the art medical technology and health care, this place has since been taken over by private medical care institutions. By improving the primary health care system and strengthening referal services, the medical colleges should be left free to concentrate

n research and training. Centres of excellence in particular areas can be developed under the medical colleges. One of the necessary conditions in improving the quality of medical education is the banning of private practice by medical college faculty. Teaching Staff of the medical college should be well compensated, and should be free to develop their academic and research interests. The administrative setup in the medical colleges should be revamped so that more decisions can be made at the college level. General practice should be developed to the level of a speciality with degree status from the colleges.

Nursing education in the state is to a large extent the domain of private hospitals. More opportunities for training nurses should be available in the government sector. Exploitation of nursing trainees as cheep labour by private institutions should be stopped, and training programmes in the private sector brought under strict quality control. Opportunities for degree and higher courses in nursing should be available The state can think of converting some of the ANM training centres to nursing schools as there are adequate number of ANM's in the state now, and their job opportunities outside the state sector are limited.

There is a shortage of trained male health workers in the state. Hence the course for training Junior Health Inspectors (male health workers) should be continued. Their training can be modified to suit the needs of Kerala. More emphasis need be given to disease detection and prevention. Schools for male supervisory personel may also be thought of.

Shortages of X-ray technicians,lab. technicians, pharmacists, and other technicians should be remedied. The nursing assistants in the state hospitals are promoted from the ranks of class IV employees without training. This can be corrected by either giving training to them immediately after promotion, or creating a separate cadre of nursing assistant with appropriate qualification.

Training in the Ayurveda, Homoeo and other systems of medicine tends to be neglected now. Their contribution to the health services need to be strengthened by an integrated approach. Proper qualifications for registration, as well as for appointment as teachers in the training institutions, need to be fixed in consultation with apex bodies. Training for paramedical personnel in these systems also has to be revised.

## RURAL HEALTH SERVICES

The basic unit of rural health services in Kerala is the sub centre. There is one male health worker (junior health inspector) and one female health worker (junior public health nurse) for every 5000 population in the plains; and one male and female health worker per 3000 population in the hilly areas. They are supposed to visit each of the households under their area of care at least once a month. But there are grounds to believe that for various reasons this is not taking place. The subcentre, which can take care of all minor ailments and most preventive interventions, is not now in a position to function properly because of lack of provision of drugs and other necessities. It is necessary that the curative component in the subcentre activities be strengthened so that the health workers have credibility with the rural population. Hence it is imperative to improve the standing of the subcentres in the rural health care network.

It will be ideal to have a primary health centre in each panchayat which is to be brought under the control of the panchayat itself in most administrative matters, so that local health problems can be dealt with locally. The medical officer (s) of the PHC can supervise the other health staff. To assist him, as at present, there shall be the male and female health supervisors, or health inspectors. At present there are one female health inspector to every four junior public health nurses, and one male health inspector to every four junior health inspectors. If, as planned, we can have a primary health centre for every 30,000 population (roughly one panchayat), then

there need be one male and one famale health supervisor to look after the six male and six female health workers under the PHC.

The next level of care is envisaged to be the community health centre (CHC). There can be one CHC to every 4 PHCs. All the primary care specialities should be available in the CHC, such as medicine, gynaecology, pediatrics, surgery, and anaesthesia. By developing the block level PHCs to CHCs, we can aim to have a CHC in every block.

## URBAN HEALTH SERVICES

Most of the curative services in the state sector such as the medical college, district hospitals and taluk hospitals are situated in the urban areas in Kerala. These are either under the control of the Director of Health Services or the Director of Medical Education. But the preventive health care in the urban areas, such as immunisation, maternal and child health, antenatal, and family planning services are under the municipal health services. Unfortunately these are not functioning as they should be. In fact, preventive services such as immunisation are lagging behind in performance in urban areas when compared to rural areas.

It should be obvious that this state of affairs affects the poorer people in the towns and cities much more than the well off. Thus the health status of the poor in urban areas is worse than that of their brethren in the rural parts of Kerala.

The way out of this situation is to strengthen the municipal health services by (1) enabling them to raise more resources, (2) providing adequate manpower and supervision, and (3) empowering them to take necessary decision and action when intervention is warranted. There is a strong case for having male and female health workers attached to the municipal health centres to take care of maternal and child health and family planning activities.

## VERTICAL HEALTH PROGRAMMES

Most of the vertical health programmes are integrated into the work of the PHC now. Only National Leprosy Eradication Programme remains separate. There is a case for integrating the leprosy programme also into the PHC activities, as all other national programmes. The overemphasis given to family planning activities at present needs to be reexamined. The direction of family welfare policy in Kerala has to be redetermined now that control of fertility has more or less been achieved in the state.

## REFERAL SYSTEM

The proper functioning of the referal system depends on the peripheral units being able to cope with the greater part of the work load of primary health care. Hence the PHCs and other peripheral health care institutions need to be strengthened. Inventories of drugs and equipment should be regularly updated and these should be adequate to meet all demands of primary care. If this has been achieved, then bypass charges can be introduced in the higher level hospitals for those who directly approach the referal centres.

For efficient running of the state health sector, a managerial cadre of doctors trained in modern public health method should be created. The practice of entrusting administration in health solely on the basis of years of seniority should be abandoned.

## DRUG POLICY

The drug situation in Kerala is characterised by non-availability of even essential drugs in many government health institutions, along with overmedication of patients in the private sector and in private practice. The priorities in the drug sector should be: (1) Establishment of hospital formularies in all major hospitals and rationalisation of prescription practices. In the state health services, it will be helpful to have a state level formulary. (2) Preparation and publication of essential drug list at all levels. This should also be followed up by proper education

of professionals on rational therapeutics. (3) Streamlining drug purchases and supply at all levels of state health institutions. 'In-house' manufacturing of many of the basic items should be thought of as a cost cutting measure. (4) Updating inventory control: the present system is designed to produce a lot of inefficiencies in purchase and distribution. With modern computerised inventory control systems, it should be possible to cut down a lot of this (5) The Public sector Kerala State Drugs & Pharmaceuticals too should be strengthened as suggested by the Pai Committee so as to supply all essential drugs to the government hospitals.

Any health policy formulation for Kerala has to acknowledge the fact that the private sector accounts for a large proportion of the services rendered, and the demand for such services is fast growing. Moreover, it should be remembered that the private sector has been instrumental in providing services in many rural areas where there are no government facilities available. The private sector has also taken the initiative in recent times in introducing state of the art technology in medical care into the state, even though in many instances the relevance of these might be open to question.

But it also remains true that private hospitals have to a large extent been responsible for the commercialisation of medicine in Kerala. In the name of providing sophisticated care, they tend to overuse costly technologies and interventions such as intensive care, computerised scanning facilities, caesarian sections etc. What should be realised is that private hospitals fall into many categories. Some are truly humanitarian and service minded in their approach, whereas there are others with purely mercenary motives. Many fall in between. Hence some sort of authority, such as district and state level health boards, for categorisation and certification of private hospitals should be thought of. They should be entrusted with licensing of these facilities, inspecting the credentials of the personnel working in them, and fixing maximum rates depending on the type of care available. The introduction of costly facilities such as CT scans

in any area should be licensed only after needs assessment to make sure that the demand would be adequate. There can be fruitful collaboration between private and state hospitals in many areas such as family welfare and immunisation. Also, where the state does not have the facilities for any sophisticated intervention licensing a private unit can be made conditional on provision of free services for a proportion of the patients to be recommended by a committee.

## LABORATORY FACILITIES

Laboratory facilities in government institutions are insufficient in quantity. Private laboratories leave a lot to be desired in terms of quality control. At the minimum, there should be a prescribed number of basic investigation which it should be possible to carry out in all government institutions. This list can vary with the level of the institution, so that sophisticated investigations should be available at the medical college level. Provision should be made for emergency investigations in government hospitals at all hours. Licensing for private laboratories should be introduced, with provision for periodic quality checks. They can also be graded according to the level of service offered. Research should be undertaken to define the range of normal values in our own populations.

## WATER SUPPLY

Surveys show that the majority of households in Kerala get their drinking water from wells. But unfortunately, at present there is no way of ensuring the quality and potability of well water in most places. The health and water supply authorities have not been able to provide any sort of quality checks to the satisfaction of the people. Any public water supply scheme should have water purification facilities. It should also be possible for private citizens to have checks on water quality and potability at reasonable rates. In areas where there is scarcity of drinking water in summer, provision for supply should be made.

## SANITATION

Nearly 50% of the rural households have sanitary facilities attached to their households. Out of these 34 % are proper sanitary latrines. In urban areas the percentage of latrine use would be much more. The poorest group both in rural and urban areas have the least access to facilities A lot of research has to go into the design, organisation and provisions of sanitary latrines to rural areas, especially over-crowded coastal settlements where the pressure on land is tremendous. The problem is complicated by water shortage in the summer months. In many parts of Kerala, the demand for sanitary latrines from the people cannot be met by the local bodies or government agencies for shortage of funds. Innovative funding schemes should be found for this.

## NUTRITION AND SCHOOL FEEDING

Kerala is one of the states where the per capita Calorie consumption is below the national average, even though the prevalence of severe forms of mainutrition is the lowest. Kerala is dependent on imported food grains to a great degree Our priority should be to enhance food production in the state, especially food grains and vegetables, so that food prices can be under better control.

The feeding programmes envisage providing 300 calories and 8-12 grams of protein per beneficary in the 0-6 age group, and 500 calories and 25 grams of protein per pregnant/nursing mother, for 300 days a year. This is provided through the ICDS projects in the state. Besides this, there is the school meal programme. It will be ideal to restrict noon meal to the needy and eligible students. It is better that in all feeding programmes, locally available foodstuffs are cooked under supervision and given to the students, rather than introducing alien cuisine. School meal programmes provide scope for a lot of local participation.

## THE INDIGENOUS SYSTEM

Other than modern medicine or allopathy, a number of other systems of medicine are resorted to by the people at various times and for various diseases. These include ayurveda, homoeopathy, unani, siddha, nature cure and some others. It is obvious that these systems fulfil a felt need of the people for alternate therapy. Hence the free choice of the people in this matter needs to be encouraged. Both in the government as well as the private sector, all other systems of medicine should be available to the extent that there is demand for them. But encouragement of these systems should not jeopardise the realisation of the paramount obiectives of health policy such as universal immunisation, provision of primary health care, provision of essential drugs etc. Measures of quality control and research into efficacy and efficaciousness should be carried out in the alternative systems also.

## NON GOVERNMENTAL AGENCIES

Non governmental agencies in health have an important role to play in Kerala. They should be encouraged in efforts to give health education, and in mobilisation of the people for the right kind of health programmes. They can play a role in the social audit of health care.

## HEALTH INFORMATION AND MANAGEMENT

A neglected area in modern health care in kerala is health information systems and health management. Data on communicable as well as chronic diseases such as coronary heart disease, strokes, should be collected and published routinely. This should include not only incidence-prevalence data, but also such details as hospitalisation rates, outcomes, longterm follow ups etc. Data should also be available on hospitals, facilities available, costs of care, utilisation rates etc,

so that planning in health can be put on a much more scientific basis. To facilitate this, there should be an agency modelled on the national sample survey organisation, for the state. This can augment the data collection by the department of economics and statistics, and the planning board. The investment in this regard will be more than compensated by the returns. Along with this, management in the health sector should be put on a more modern basis, with training imparted to key professionals who shall be in decision making roles. At present the Institute of Managemenr in Government is doing some efforts in this direction, but it cannot be said to be very effective. It will be ideal to have an institution in the state for raining and research in the areas of epidemiology and health economics, policy, financing etc. in the form of an Insiitute of managent in health which shall also oversee the health informatlon collection.

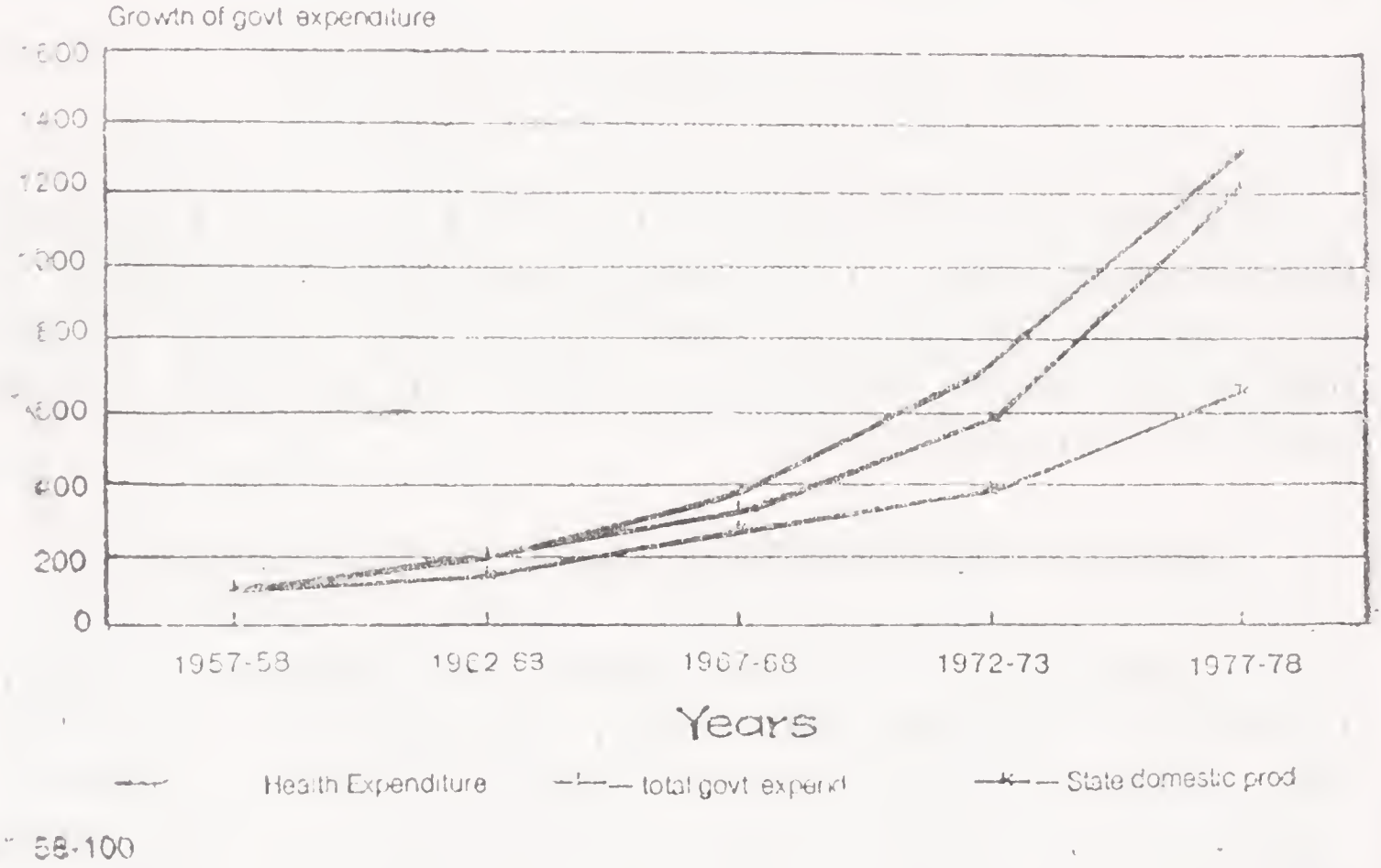


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Figure 1: Graph of Total Government Expenditure. Government Expenditure on health and State Domestic product in Kerala from 1957 to 1978.

Per Capita Expenditure on medicine and public health in Kerala.

| Year | Expenditure (lakhs) | Index | Expenditure/ Capita | Index |
|---|---|---|---|---|
| 1980—81 | 4857·25 | 100 | 19.13 | 100 |
| 1881—82 | 5811.56 | 120 | 22.88 | 119 |
| 1982—83 | 5907.12 | 122 | 22.76 | 119 |
| 1983—84 | 6946.80 | 143 | 25.88 | 135 |
| 1984—85 | 8841.13 | 182 | 32.73 | 170 |
| 1985—86 | 11082 09 | 228 | 40.44 | 211 |
| 1986—87 | 13789.93 | 284 | 50.13 | 262 |
| 1987—88 | 15970.65 | 328 | 55 37 | 289 |

Source : Economic Review, 1988

## Foot notes

1. These figures are modified estimates from *Department of* Economics and Statistics : *"Statistics for Planning" Thiruvananthapuram 1988*·

2. From Panikar PGK and Soman CR *Health Status of Kerala: The Paradex of Economic Backwardness and Health Development* Thiruvananthapuram, the Centre for Development Studies 1984.

3. *Health Status of Rural Kerala*, Thiruvananthapuram The Kerala Sastra Sahitya Parishad 1991.

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